Colorectal Symptoms & Suspected Colorectal Cancer

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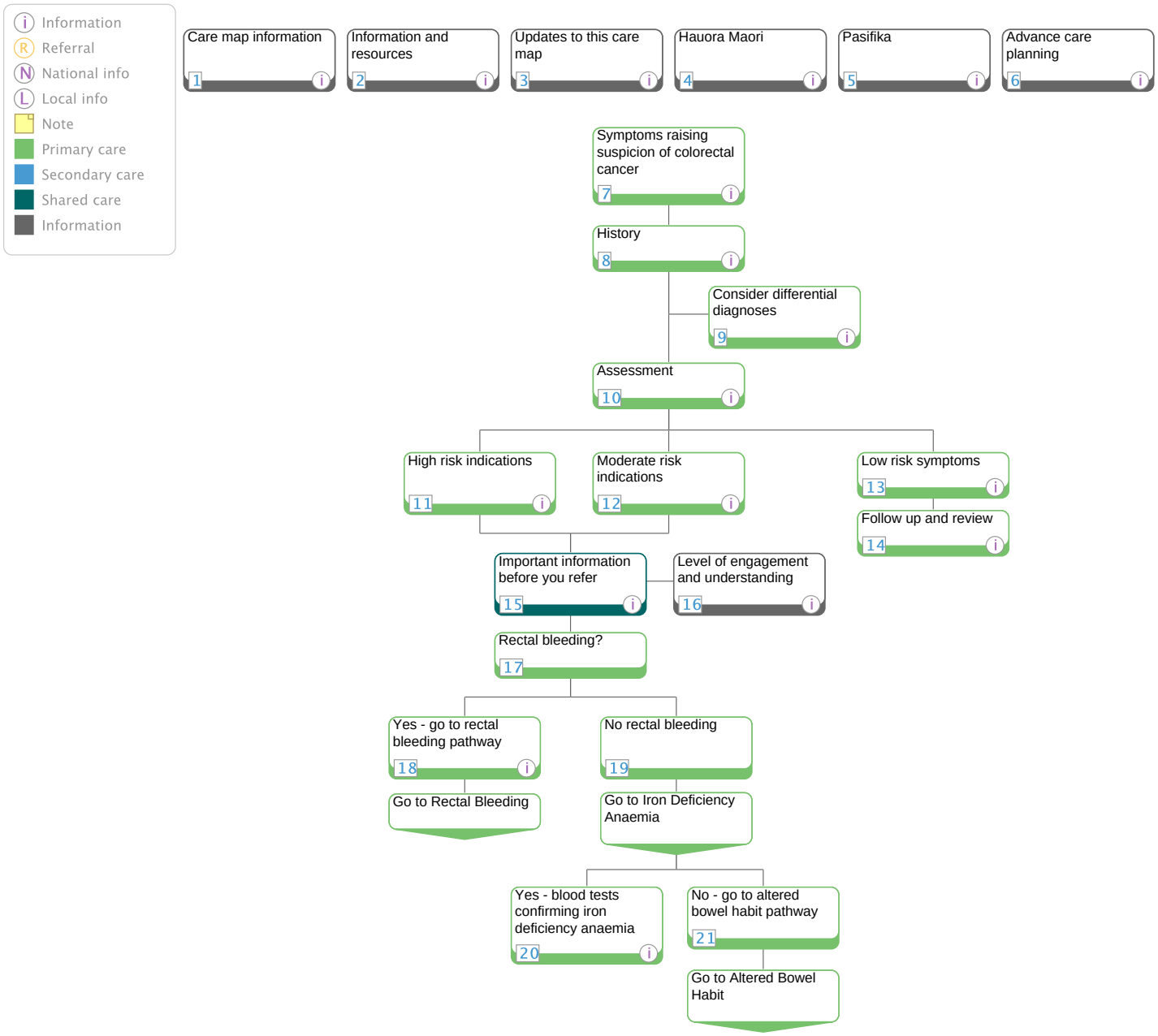

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Colorectal Symptoms & Suspected Colorectal Cancer

1 Care map information

Quick info:

The aim of this pathway is to:

- explain risk assessment (high, moderate and low) to referrer
- aid prompt diagnosis of colorectal cancer for patients presenting with 'high' or 'moderate' risk symptoms
- **avoid inappropriate use of colonoscopy and faecal calprotectin (FCP)**
- direct referral of people to the most appropriate service
- help referrer provide adequate information for prioritisation or use accepted indications to make a referral with all required information
- support referrer to 'treat and review' people with 'low risk' symptoms
- the 'symptom' pathways are only suitable if 'rectal bleeding', 'altered bowel habit' or 'iron deficiency anaemia' is present

In scope:

Colorectal symptoms:

- suspicion of colorectal cancer
- risk indications

Out of scope:

- iron deficiency anaemia
- rectal bleeding
- altered bowel habit

NB:

- **hospital services are responsible for all recalls if required**
- Maori are 30 percent less likely than non-Maori to get bowel cancer but once diagnosed are 30 percent more likely to die from bowel cancer [1]
- Pacific and Asian New Zealanders have substantially lower incidence and mortality from bowel cancer than other New Zealanders [3]

Incidence:

In 2008, colorectal cancer was the second most common cancer registered and the second most common cause of death in New Zealand accounting for 14% of all cancer registrations and 15% of all deaths from cancer [2]. Men have considerably higher rates of rectal cancer [3]. Each year between 2500 and 3000 New Zealanders will be diagnosed with colorectal cancer and between 1,100 and 1,200 will die as a result of colorectal cancer [2].

In 2008, colorectal cancer was the fourth most commonly registered cancer and third most common cause of death from cancer for Maori compared to non-Maori where colorectal cancer was the second most commonly registered cancer and cause of death from cancer.

References

[1] Central Cancer network, Regional Bowel Cancer workplan 2014

[2] Ministry of Health. (2008). Cancer: New registrations and deaths 2008. Wellington: Ministry of Health.

[3] Blakely, T., Shaw, C., Atkinson, J., Tobias, M., Bastiampillai, N., Sloane, K et al. Cancer trends: Trends in incidence by ethnic and socioeconomic group, New Zealand 1981-2004. Wellington, New Zealand: Ministry of Health.

2 Information and resources

Quick info:

Resources for people and their carers:

- colonoscopy - a patient guide
- beat bowel cancer - tests
- Colorectal Surgical society of Australia and New Zealand
- Cancer Society - bowel cancer

Language translation assistance:

HBDHB Interpreting Service. To make an appointment (charges may apply):

- phone 06 878 8109 ext 5805 or

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- email interpreting@hawkesbaydhb.govt.nz

These websites may help with simple words and phrases:

- Babelfish
- Google translate
- Language Line
- Professional interpreters are available, free of charge, for telephone-based sessions (44 languages are supported):
  - Phone 0800 656 656
  - Monday - Friday 9am - 6pm
  - Saturday 9am - 2pm

Bookings are not usually necessary. For longer consultations (for example, a nurse consultation for a newly diagnosed person) it is best to make a booking at least 24 hours in advance by calling the above number or emailing language.line@dia.govt.nz and providing your contact details and a summary of the service you require (time and date of the meeting, language, approximate length of the appointment, gender of interpreter (if relevant).

3 Updates to this care map

Quick info:

Date of publication September 2016

Review date: March 2017

This care map has been developed in line with consideration to evidenced based guidelines. For further information on contributors and references please see the Pathway's Provenance Certificate.

NB: This information appears on each page of this care map.

4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whakawhanungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from or to where they have significant connections
- asking Maori people if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori people about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues

Maori health services

HBDHB contracts Maori health providers to deliver community based nursing and social support services. A referral to one of these providers may assist Maori people to feel more comfortable about receiving these services.

Central Hawke's Bay:

Central Health

Cnr Herbert & Ruataniwha Streets, Waipukurau

Phone: 06 858 9559 Fax: 06 858 9229

Email: reception@centralhealth.co.nz

Referral Form

Hastings:

Te Taiwhenua o Heretaunga

821 Orchard Road, Hastings 4156

Phone: 06 871 5350 Fax: 06 871 535

Email: taiwhenua.heretaunga@ttoh.iwi.nz

Referral Form

Kahungunu Health Services (Choices)
500 Maraekakaho Road, Hastings
Phone: 06 878 7616
Email: kahungunu@paradise.net.nz
Referral Form

Napier:
Te Kupenga Hauora
5 Sale Street, Napier
Phone: 06 835 1840
Email: info@tkh.org.nz
Referral Form

Wairoa:
Kahungunu Executive (no website)
65 Queen Street, Wairoa 4108
Phone: 06 838 6835 Fax: 06 838 7290
Email: kahu-exec@xtra.co.nz

Secondary Care Maori Health Services:
Hawke's Bay DHB - Te Wahanga Hauora Maori Health Services
Phone: 06 878 8109 ext. 5779, 06 878 1654 or 0800 333 671 Email: admin.maorihealth@hawkesbaydhb.govt.nz

Further Information

Practitioners should be versed in the knowledge of:

- historical overview of legislation that impacted on Maori well-being
- Maori models of health, such as Te Whare Tapa Wha and Te Wheke when working with Maori whanau
- national Maori Health Strategies:
  - **Mai Maori Health Strategy 2014-2019** - Full file or Summary diagram
  - **He Korowai Oranga**: Maori Health Strategy - sets the Government's overarching framework to achieving the best health outcomes for Maori
- local Hawke's Bay health sector's strategies and initiatives for improving Maori health and wellbeing

Cultural Competency Training

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori people. Contact the coordinator via email: education@hbdhb.govt.nz to request details of the next courses.

5 Pasifika

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you in order to help you work with Pacific people more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up two thirds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge The FonaFale Model (Pacific model of health) when working with Pacific people and families.

General guidelines when working with Pacific people and families (information developed by Central PHO, Manawatu):

- Cultural protocols and greetings
- Building relationships with your Pacific people
- Involving family support and religion during assessments and in the hospital
- Home visits

Hawke's Bay-based resources:

- HBDHB interpreting service website **or** phone 06 8788 109 ext 5805 (no charge for the hospital; charges may apply for community-based translations) **or** contact coordinator at interpreting@hbdhb.govt.nz
- **Pacific Navigation Services Ltd** Phone: 027 971 9199
- services to assist Pacific people to access healthcare (SIA)
- Improving the Health of Pacific People in Hawke's Bay - Pacific Health action Plan

Ministry of Health resources:

- Ala Mo'ui Pathways to Pacific Health and wellbeing 2014-2018
- Primary Care for Pacific people: a Pacific and health systems approach
- Health education resources in Pacific languages (links to a web page where you can download resources)

6 Advance care planning

Quick info:

Advance Care Planning:

Advance Care Planning is a voluntary process of discussion and shared planning for future health care. It involves the person who is preparing the plan, and usually involves family/whanau and health care professionals.

Advance Care Plan:

An Advance Care Plan is the outcome of Advance Care Planning. It is formulated by the person and sets out their views about care towards the end of their life. It may also include views about medical care and a wide range of other matters. An Advance Care Plan may include an Advance Directive.

Advance Directive:

An Advance Directive is a statement a person makes about their medical care in the future and becomes effective if a person ceases to be competent to make decisions for themselves. An Advance Directive is legally binding if made in appropriate circumstances.

Competency and Advance Care Planning:

Competent people have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the person's longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Acts.

According to ACP - A Guide for the NZ Health Care Workforce - "in the context of ACP, competency relates to an individual's ability to make a decision regarding their own health care (that is, competence at decision-making or decision-capacity). At a minimum, decision making capacity requires the ability to understand and communicate, to reason and deliberate, and the possession of a set of values".

Helpful websites:

- The code of rights
- Advance care planning guide Ministry of Health
- Advance care planning resources

7 Symptoms raising suspicion of colorectal cancer

Quick info:

The incidence of colorectal cancer increases substantially with increasing age. 90% of colorectal cancers are diagnosed in patients aged ≥50 years.

Most people with suspected colorectal cancer will present with:

- rectal bleeding (with or separate from the faeces)
- colorectal cancer presenting with altered bowel habit, is most likely to cause “looser and/or more frequent stools
- changes in bowel habit, such as:
  - increased frequency of defaecation

- looser stools
- constipation and alternating constipation/diarrhoea are **uncommon** presentations of colorectal cancer

- non-specific symptoms, e.g. tiredness due to undetected blood loss
- most (80 - 90%) symptomatic colorectal cancers present with rectal bleeding, altered bowel habit or iron deficiency anaemia - alone or in combination
- other presentations of colorectal cancer include:
  - symptoms of metastatic disease
  - acute or intermittent intestinal obstruction (may present as intermittent pain and nausea/vomiting, worse after eating) intestinal obstruction
  - abdominal or rectal mass

Other presenting complaints include:

- feeling of bloatedness
- weight loss (usually weight loss is a late symptom associated with metastatic disease or other complications - consider other causes)
- malaise
- mucus in the faeces

NB: these however are non-specific and can be related to multiple other pathologies. Alternative explanations should be sought where these are the predominant symptom without evidence of rectal bleeding, changes in bowel habit, iron deficiency anaemia or other associated risk factors for colorectal cancer.

People with cancers proximal to the sigmoid colon may present with:

- intestinal obstruction
- iron deficiency anaemia – defined as both a haemoglobin and ferritin below the reference range for age and gender
- abdominal mass

8 History

Quick info:

Ask the person about:

- onset and duration of symptoms, e.g:
  - rectal bleeding
  - changes in bowel habit
- risk factors, e.g:
  - inflammatory bowel disease (IBD)
  - personal history of adenomatous polyps
  - personal history of colorectal cancer
  - diet
  - drugs
  - smoking
- systemic symptoms, e.g:
  - weight loss
  - anorexia
  - fatigue
- positive family history of colorectal cancer

Equity:

- Maori people have poorer survival rates for colorectal cancer. Consider early referral in this group
- ask all of your people if they smoke
- tobacco use is the single most preventable cause of disease, disability and death in New Zealand. Maori smoking prevalence is over double of non-Maori prevalence. Give all of your people who smoke, brief advice to quit and nicotine replacement therapy (NRT). If you have no NRT on hand, a prescription or Quit card will suffice. There is no need to assess readiness to

quit. Give an NRT prescription or Quit card to all people. Ask permission to refer each person for cessation support either with a community based provider or to Quitline. Tobacco control should also be discussed with the person's household and family members
- offer and refer your Maori people for socioeconomic support

9 Consider differential diagnoses

Quick info:

Differential diagnoses include:

- inflammatory bowel disease (IBD):
  - crohn's disease
  - ulcerative colitis
- irritable bowel syndrome (IBS), must not have bleeding
- haemorrhoids
- benign polyps
- non-pathological constipation or faecal incontinence
- infective colitis (including sexual transmitted diseases)
- coeliac disease
- medication-related, e.g. erythromycin use
- anal cancer

10 Assessment

Quick info:

Intended for the stable outpatient with overt lower gastrointestinal bleeding

This section does not apply to:

- melaena
- large volume acute gastrointestinal haemorrhage
- occult bleeding (iron deficiency anaemia)

Assessment:

- history
- examination
- +/- treatement
- C-Reactive Protein (CRP), full blood count (FBC), creatinine and full iron studies profile
- **digital rectal examination**

Assess people for:

- weight loss
  - where signs of malnutrition are present, complete a validated nutrition screening tool, e.g. Malnutrition Universal Screening Tool (MUST)
- signs of cachexia
- anaemia:
  - all people with unexplained iron deficiency anaemia should be referred to Gastroenterology service
  - menstruation is the commonest cause of iron deficiency anaemia in women - for women aged < 55 years a menstrual history should be obtained prior to referral
- coeliac disease and urinary loss should also be excluded
- abdominal distension
- palpable abdominal mass
- palpable lymph nodes

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- signs of obstruction or acute abdomen
- **digital rectal examination (DRE)**
- vaginal examination
- assessment of the presence of a palpable rectal mass (if there is uncertainty regarding the mass, the person should be re-examined after treatment with laxatives)

11 High risk indications

Quick info:

Accepted criteria for urgent (<2 week priority):

- known or suspected colorectal cancer (on imaging, or palpable, or visible on rectal examination), for pre-operative procedure to rule out synchronous pathology
- unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin and ferritin below the local reference range)
- altered bowel habit (looser and/or more frequent) >6 weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years

NB: all referrals are directed to Secondary Services who will access prioritisation for colonoscopy.

National Referral Criteria for Direct Access Outpatient Colonoscopy

12 Moderate risk indications

Quick info:

Accepted criteria for non-urgent (<6 weeks priority):

- altered bowel habit (looser and/or more frequent) > six weeks duration, aged ≥ 50 years
- altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded), aged 40 - 50 years
- unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years
- unexplained iron deficiency anaemia (haemoglobin and ferritin below local reference range)
- Category 2 Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 40 years
- Category 3 Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 25 years
- suspected/assessment inflammatory bowel disease (consider FSA)
- imaging reveals polyp > 5mm

NB: all referrals are directed to Secondary services who will access priori sat ion for colonoscopy.

National Referral Criteria for Direct Access Outpatient Colonoscopy

13 Low risk symptoms

Quick info:

The following are not accepted as indications:

- acute diarrhoea <6 weeks duration - likely infectious aetiology and self-limited
- rectal bleeding aged <50 years (normal haemoglobin) - consider ***FSA*** or flexible sigmoidoscopy if no anal cause
- irritable bowel syndrome (may require specialist assessment)
- constipation as a single symptom
- uncomplicated computed tomography (CT) proven diverticulitis without suspicious radiological features
- abdominal pain alone without any '6 week category' features
- decreased ferritin aged < 50 years with normal haemoglobin
- abdominal mass - refer for appropriate imaging

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- metastatic adenocarcinoma unknown primary - 6% is due to colorectal cancer (CRC) and in the absence of clinical, radiological, or tumour marker evidence of CRC

NB: all referrals are directed to Secondary services who will access prioritisation for colonoscopy

National Referral Criteria for Direct Access Outpatient Colonoscopy

14 Follow up and review

Quick info:

Follow up and review:

- review in 3 - 6 months
- consider referral to colorectal specialist if the patient experiences persistent symptoms

15 Important information before you refer

Quick info:

In referring a person the referrer should:

- consider whether the person being referred will benefit if they are frail, have multiple co-morbidities or advanced malignancy (general referral implies they are well enough to tolerate further treatment)
- if the person had a colonoscopy in the preceding 5 years, ensure there is a clear indication to repeat the procedure (the 'miss' rates of lesions > 1cm following a well performed colonoscopy is approximately 6%)

NB: Secondary Services are responsible for all recalls if required

16 Level of engagement and understanding

Quick info:

Assess the person's level of understanding and engagement in medical care. Consider the person's choice and general state of health before proceeding i.e:

- person is terminal or elderly and frail
- has significant co-morbidities
- may not tolerate any sort of treatment
- may not want to pursue further diagnostic testing
- hearing impairment
- cultural background and belief systems
- anxiety or extreme emotional intensity

Consider barriers to effective care:

Factors that could stop the person from getting further tests or treatment:

- health literacy:
  - english as second language
  - understanding medical terminology, use layman terms
  - what happens next
- locality and geographic access to health and hospital services (travel)
- socio-economic factors including source of income (work commitments and responsibilities)
- complexity of cancer care pathway not knowing when or where to go next
- family/whanau and social network dynamics
- family/whanau support, family history

18 Yes - go to rectal bleeding pathway

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Quick info:

20 Yes - blood tests confirming iron deficiency anaemia

Quick info:

Results of full iron studies (to include ferritin) and C-Reactive protein (CRP) to confirm iron deficiency anaemia - **Alaina to link**

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Provenance Certificate – Colorectal Cancer

Overview
This document describes the provenance of Hawke's Bay Regions Colorectal Cancer Pathways.

The purpose of implementing cancer pathways in our District is to:

- Reduce barriers so that all people with cancer are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status
- Achieve the faster cancer treatment (FCT) health target – 85% of patient receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017
- Implement the national tumour standards of service provision, developed as part of the FCT programme, to support the delivery of standardised quality care for all people with cancer
- Improve equity along the cancer pathway
- Clarify expectations across providers
- Improve communications and follow up care for cancer patients

To cite these pathways, use the following format:

- Map of Medicine – Hawke's Bay View / Oncology /Colorectal Cancer / Colorectal Symptoms & Suspected Colorectal Cancer
- Map of Medicine – Hawke's Bay View / Oncology /Colorectal Cancer /Altered Bowel Habit (ABH)
- Map of Medicine – Hawke's Bay View / Oncology /Colorectal Cancer /Rectal Bleeding
- Map of Medicine – Hawke's Bay View / Oncology /Colorectal Cancer /Unexplained Iron Deficiency Anaemia
- Map of Medicine – Hawke's Bay View / Oncology /Colorectal Cancer /Surveillance Colonoscopy – Personal and Family History

Editorial methodology

This care map has been based on a Map of Medicine Care Map developed according to the Map of Medicine editorial methodology. The content of the Map of Medicine care map is based on high quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience (see contributors section of this document). This localised version of the evidence-based, practice informed care map has been peer-reviewed by the WDHB and WRHN Collaborative Clinical Directors and Leaders Forum and with stakeholder groups.

References

1	Ministry of Health. (2008). Cancer: New registrations and deaths 2008. Wellington: Ministry of Health
2	Blakely, T., Shaw, C., Atkinson, J., Tobias, M., Bastiampillai, N., Sloane, K et al. Cancer trends: Trends in incidence by ethnic and socioeconomic group, New Zealand 1981-2004. Wellington, New Zealand: Ministry of Health.
3	Maori Health Profile 2015 – Cancer by DHB Region
4	Central Cancer network, Regional Bowel Cancer workplan 2014

Contributors

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Disclaimers

Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay.

It is not the function of the Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care.

Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.